

COUNTY OF LOS ANGELES

OFFICE OF THE COUNTY COUNSEL

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TDD

JOHN F. KRATTLI Acting County Counsel

April 18, 2012

TO:

SACHI A. HAMAI Executive Officer

Board of Supervisors

Attention: Agenda Preparation

FROM:

PATRICK A. WU

Senior Assistant County Counsel

RE:

Item for the Board of Supervisors' Agenda County Claims Board Recommendation Denise Hines, et al. v. County of Los Angeles

Los Angeles Superior Court Case No. BC 445 797

Attached is the Agenda entry for the Los Angeles County Claims Board's recommendation regarding the above-referenced matter. Also attached are the Case Summary and the Summary Corrective Action Plan to be made available to the public.

It is requested that this recommendation, the Case Summary, and the Summary Corrective Action Plan be placed on the Board of Supervisors' agenda.

PAW:rfm

Attachments

Board Agenda

MISCELLANEOUS COMMUNICATIONS

Los Angeles County Claims Board's recommendation: Authorize settlement of the matter entitled <u>Denise Hines</u>, et al. v. County of <u>Los Angeles</u>, Los Angeles Superior Court Case No. BC 445 797, in the amount of \$299,999 plus the assumption of the Medicare lien in the estimated amount of \$38,875.22 and instruct the Auditor-Controller to draw a warrant to implement this settlement from the Department of Health Services' budget.

This wrongful death lawsuit arises from injuries sustained by a patient while hospitalized at LAC+ USC Medical Center.

CASE SUMMARY

INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME Denise Hines, et al. v. County of

Los Angeles

CASE NUMBER BC 445797

COURT Los Angeles Superior Court

Central District

DATE FILED September 17, 2010

COUNTY DEPARTMENT Department of Health Services

PROPOSED SETTLEMENT AMOUNT \$299,999, plus the assumption of

the Medicare lien in the estimated

amout of \$38,875.22.

ATTORNEY FOR PLAINTIFF Shirley K. Watkins

Law Offices of Michels & Watkins

COUNTY COUNSEL ATTORNEY Narbeh Bagdasarian

NATURE OF CASE On October 14, 2009, Burleigh

Hines, a 77-year-old male, was admitted to LAC+USC Medical Center. On October 20, 2009, the

patient was found on the floor.

Diagnostic tests showed that the patient had a bleeding in his brain.

The patient's condition

deteriorated, and on November 9,

2009, the patinet died.

Mr. Hines' family brought an action

against the County of

Los Angeles, claiming that the staff at LAC+USC Medical Center were negligent in allowing the patient to fall from his bed thereby causing injuries that contributed to

the death of the patient.

PAID ATTORNEY FEES, TO DATE	\$18,704
PAID COSTS, TO DATE	\$313.67

Case Name: Hines, Burleigh #9913

Summary Concessive Aggor: Plan



The intent of this form is to assist departments in writing a corrective action plan summary for attachment to the settlement documents developed for the Board of Supervisors and/or the County of Los Angeles Claims Board. The summary should be a specific overview of the claims/lawsuits' identified root causes and corrective actions (status, time frame, and responsible party). This summary does not replace the Corrective Action Plan form. If there is a question related to confidentiality, please consult County Counsel.

Date of incident/event:	10/20/09
Briefly provide a description of the incident/event:	On October 14, 2009, Burleigh Hines, a 77-year-old male, was admitted to LAC+USC Medical Center. On October 20, 2009, the patient was found on the floor. Diagnostic tests showed that the patient had bleeding in his brain. The patient's condition deteriorated, and on November 9, 2009, the patient died.

- Briefly describe the <u>root cause(s)</u> of the claim/lawsuit:
 - Bleeding in the brain after a fall resulting in death
- Briefly describe recommended corrective actions: (Include each corrective action, due date, responsible party, and any disciplinary actions if appropriate)
 - All appropriate personnel corrective actions have been taken
 - A system wide and outside-DHS survey was conducted to determine the practices in place for assessing patients for risk of falls. All DHS acute care facilities have a process in place to assess patients for risk of falls. DHS is standardizing the tool used for this assessment.
 - A system wide survey was conducted to determine the preventative measures in place to reduce the risk of falls. It was determined that each DHS acute care facility utilizes preventative measures to reduce the risk of falls.
 - A system wide survey was conducted to determine chain-of-command procedures for nursing staff. It was determined that all DHS acute care facilities have a chain-ofcommand policy for nurses to follow.
 - A system wide survey was conducted to identify the procedures for medication order processing. It was determined that all of the DHS acute care facilities have guidelines in place for medication order processing, including discontinuation, STAT orders, and 'black box warning' medications.

3.	Sta (If t	State if the corrective actions are applicable to only your department or other County departments: (If unsure, please contact the Chief Executive Office Risk Management for assistance)			
		Potentially has County-wide implications.			
		Potentially has an implication to other departments (i.e., all human services, all safety departments, or one or more other departments).			
	X	Does not appear to have County-wide or other department implications.			

Name: (Risk Management Coordinator)	
Limberly McKenie	
Signature: MNUCLMU	Date: / C / 18/ 11
Name: (Department Head)	
Hal Yee	
Signature:	Date: 1/16/1/
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Chief Executive Office Risk Management	
Name: GO COSTAN 77WO	
Signature:	Date: 10-18-2011